STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265303	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Carondelet LLC	621 Carondelet Drive Kansas City, MO 64114

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain the ceiling vents in the A Hall shower room free from a heavy buildup of dust; and failed to maintain the table top fans in the following areas free from a heavy buildup of dust: Resident room B10, Resident #33's room, Resident room B4, Resident room C5, and Resident #101's room. This practice potentially affected at least 30 residents who used the shower room and resided in those areas. The facility census was 105 residents. 1. Observation on 1/13/26 at 11:22 A.M., with the Facility Maintenance Director showed a heavy buildup of dust on two ceiling vents in the A Hall shower room. During an interview on 1/13/26 at 11:23 A.M., the Facility Maintenance Director said:-He/She needed to develop a schedule for cleaning those ceiling vents.-He/She had not had a chance to develop a schedule because he/she only took over as the Director in December 2025.Observation on 1/13/26 at 11:33 A.M., with the Facility Maintenance Director showed:-A heavy buildup of dust on the tabletop fan in resident room B5. -At the time, there were no residents present to interview about the dust buildup in the fan.Observation on 1/13/26 at 11:53 A.M., with the Facility Maintenance Director showed a heavy buildup of dust on the fan in Resident #33's room.During an interview on 1/13/26 at 11:53 A.M., Resident #33, a resident identified by the quarterly Minimum Data Set (MDS- a federally mandated assessment tool completed by the facility for care planning), dated 4/18/25, who was cognitively intact said the facility staff cleaned his/her fan every now and then, but would prefer they cleaned the fan more often.Observation on 1/13/26 at 11:56 A.M., with the Facility Maintenance Director showed:-A heavy buildup of dust on the tabletop fan in resident room B4.-At the time, there were no residents present to ask about the dust buildup in the fan.Observation on 1/13/26 at 1:28 P.M., with the Facility Maintenance Director showed:-A heavy buildup of dust on the fan in resident room C5. -At the time, there were no residents present to interview about the dust buildup in the fan.Observation on 1/13/26 at 1:32 P.M., with the Facility Maintenance Director showed a heavy buildup of dust on the fan in Resident #101's room.During an interview on 1/13/26 at 1:32 P.M., Resident #101, a resident identified by the quarterly MDS dated [DATE] who was cognitively intact, said it has been a while since they cleaned the fan on his/her side of the room and he/she would appreciate it if the facility staff cleaned his/her fan a little bit more. 2685006

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident's food preferences were honored, and alternative menu choices were provided for three sampled residents (Resident #95, #110, and #112), out of 21 sampled residents and had the potential to affect all residents who were bed bound, did not eat in the dining room area, and who ate meals in their room. The facility census was 105 residents. Review of the facility policy titled Meal Service revised dated May 2024 showed:-Meals were served three times per day. Snacks were served as ordered and at bedtime.-The dietary department delivers trays to the nursing units and dining rooms.-All nursing personnel and other available facility staff help with delivering trays and feeding residents as needed.-Residents were encouraged to eat in the dining room.-Individual preferences of residence regarding seating arrangements and where they eat were accommodated as much as possible.-When the tray was delivered, the staff ensures that the correct tray was given to the correct resident and the diet on the card matches what was on the tray.-Trays were delivered to residents at the same table at the same time.-If a resident does not like the food served, a substitute was offered.-If a resident does not eat and does not want a substitute, staff would alert the nurse for appropriate follow up. 1. Review of Resident #95's Face Sheet showed he/she was admitted on [DATE] with diagnoses which included, difficulty in walking, dysphagia (inability or difficulty swallowing) and muscle weakness. Review of the resident's Care Plan dated 3/14/25 showed:-The resident had the potential for alterations in nutrition and hydration related to being at risk for malnutrition and acute illness. Interventions instructed the nursing staff to:--Monitor and document as needed if the resident refused to eat. Review of the resident's progress notes showed there was no documentation of the resident refusing meals or meal preferences. During an interview on 1/11/26 at 4:19 P.M., with the resident while in the room and in his/her bed said:-He/She did not get to make choices about meal items and staff just brought him/her whatever they wanted. -His/her sister brought in food at times, but it was not on a regular schedule. -He/she preferred the food be hot or at least warm. During an interview on 1/12/26 at 8:20 A.M., with the resident while in the room and in his/her bed said he/she did not get to choose menu items, food was cold, and he/she was not offered an alternative by the person serving the tray. Observation on 1/13/26 at 9:29 A.M., showed the resident:-Was in the room in the bed with his/her breakfast tray on the bedside table in front of him/her.-He/She did not have the oatmeal listed on the resident's meal ticket dated 1/13/26. -The meal ticket section labeled dislikes and other were both blank. During an interview on 1/13/26 at 9:29 A.M. the resident said:-He/she did not choose the menu items.-He/she was told they were out of oatmeal and was not offered an alternative.-No alternative (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	menu was offered to resident. Observation on 1/14/26 at 8:45 A.M., showed:-The resident was provided with a breakfast meal tray in his/her room.-Oatmeal was listed on meal ticket but not provided.-The dislikes and other section on meal ticket were blank.-He/She refused the meal due to it being cold and not having menu items he/she wanted.-No alternative menu was offered. During an interview on 1/16/26 at 10:40 A.M., Certified Nursing Assistant (CNA) G said:-He/she knew what the resident's preferences and choices were by looking at the meal ticket or chart.-Updates to the resident's preferences could be found in the resident's electronic medical record.-He/she found out what the resident's preferences were by asking the nurse.-If a resident refused a meal, he/she would offer alternatives and go to the kitchen to order.-Choices and preferences were communicated to dietary by telling dietary.-He/she had been told by dietary that they were out of items in the past. During an interview on 1/16/26 at 11:11 A.M., Licensed Practical Nurse (LPN) C said:-The meal ticket should have information about the resident's preferences and choices.-Resident's choices and preferences were updated by notifying the Dietary Manager and writing a progress note.-Resident's food preferences were documented on the meal ticket, under dietary orders and in progress notes.-If the resident refused a meal staff was supposed to try to encourage, notify the dietician to give supplement and offer alternatives.-If a resident refused meals due to a lack of choice, the CNA's should let the resident know there were alternatives and offer them.-He/she had never been told that menu items were not available so he/she doesn't know what the procedure would be. During an interview on 1/16/26 at 11:55 A.M., the Executive Chef said:-He/she knew of updates to resident's diets and preferences by a progress note being made in the electronic medical record that synced with the software he/she used to create food orders and print meal tickets.-Residents were offered alternatives everyday with every meal.- the same alternative menu that was in the dining room was placed in each resident room and it was also included in the resident's welcome/admission packet. -Residents could get items that were not on the menu.-Cooks and servers were responsible for making sure that all the items listed on the meal ticket were providing on the room trays. During an interview on 1/16/26 at 12:06 A.M., the Chief Nursing Officer (CNO) said:-Resident preferences were assessed during care plan meetings, and the monthly meetings with the dietician.-Updates to resident's preferences were made by putting them in the diet order listing report daily, if on therapy they put it in an order, care plan it, it should be on the meal ticket, the residents electronic medical record notes synced to the dietary menu software.-Residents were aware that alternatives were available and had an alternative menu.-Residents were made aware by the CNA's that alternatives were available.-Residents were given an alternative menu in their welcome/admission packet. 2. During an initial interview on 1/11/26 Resident #110 who ate in his/her room said no one asked them what they wanted to eat, they just got whatever was brought to them. Observation on 1/13/2026 at 1:30 PM of the resident's lunch meal ticket did not offer alternatives nor was there a menu available. 3. During an initial interview on 1/11/26 Resident #112 who ate in his/her room said no one asked them what they wanted to eat, they just got whatever was brought to them. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 1/13/2026 at 8:45 AM of the resident's breakfast meal ticket did not offer alternatives nor was there a menu available. 4. Observation of the dining room on 1/11/26 1:20 P.M., showed: no alternative menus on the menu board or available to the residents. Observation of the dining room on 1/12/26 at 9:30 A.M., showed no alternative menus on the menu board or available to the residents. Observation of the dining room on 1/13/26 at 9:57 A.M., showed no alternative menus on the menu board or available to the residents. 5. During interview on 1/14/26 at 2:00 P.M. the Executive Chef said:-When the resident initially admitted to the facility, he/she would talk with the resident and let them know the alternative menu was in the welcome packet.-The cook and the server were supposed to make sure the residents had all the items on the meal ticket.-The resident could tell nursing staff or dietary staff if they wanted something else. During an interview on 1/15/26 at 2:15 P.M., CNA A said the CNA's would contact the kitchen and let them know if a resident wanted something else to eat. During an interview on 1/16/26 at 9:15 A.M., CNA B said the CNAs asked the residents what they wanted to eat, or the resident could call the kitchen themselves. During an interview on 1/16/26 at 9:30 A.M., LPN A said the residents could tell the charge nurse or the CNA on the floor what they wanted to eat. During an interview on 1/16/26 at 11:37 A.M., the Assistant Chief Nursing Officer (ACNO) said: -The residents would let the nursing staff know what they wanted to eat and then they would refer it to dining. -Sometimes the Executive Chef would come around, and the residents would let him/her know also. During an interview on 1/16/26 at 12:04 P.M., the CNO said:-The CNA's or the Executive Chef would go around and ask the residents what they wanted to eat.-The alternate menu was in the welcome packet.-The resident could get an alternate meal anytime.-The resident should have had an alternate menu.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to remove the dust on the vents and ceiling lights all throughout the kitchen and over-serving area; failed to ensure the walls did not have holes in them and the metal trim was falling off on a corner; failed to ensure there was a drain cover over the drain in the dish machine room; failed to ensure a large bag of bread crumbs was not open and the flour bin door was open; and failed to ensure the dining room floors were mopped. This deficient practice potentially affected all residents who ate the food from the kitchen and ate or walked through the dining room. The facility census was 105 residents. 1. Observation on 1/11/26 1:20 P.M., of the dining room showed there was dried spilled residue all throughout the sitting area. Observation on 1/11/26 1:53 P.M., during the initial kitchen walk-through showed:-Dust on the vents and ceiling lights throughout the kitchen and over-serving area. -The flour bin door was open.-A large bag of breadcrumbs was open. Observation on 1/12/26 9:30 A.M., of the dining room showed:-There was dried spilled residue all throughout the sitting area.-There was a new fresh liquid spill on the floor by a support column in the middle of the floor. Observation on 1/13/26 9:57 A.M., of the dining room showed:-There was dried spilled residue all throughout the sitting area.-There was dried spilled residue next to the support column in the middle of the floor in the same area as the liquid spill observed on 1/12/26. Observation on 1/13/26 2:47 P.M., of the dining room showed:-There was dried spilled residue all throughout the sitting area.-There was dried spilled residue next to the support column in the middle of the floor. Observation on 1/14/26 8:52 A.M., of the dining room showed:-There was dried spilled residue all throughout the sitting area.-There was dried spilled residue next to the support column in the middle of the floor. Observation on 1/14/26 from 9:36 A.M. through 12:30 P.M., during the lunch meal preparation showed:-There were holes in the wall adjacent to the serving area in the walkway on top of the trim molding.-The metal trim was coming off the corner adjacent to the bread rack. -The dish machine room had no drain cover over the drain.-The area around the piping under the prewash sink in the dish machine room was not sealed and there was a large hole with wall debris spilling out on to the floor.-There was a black substance potentially mold on the piping and around the hole under the prewash sink in the dish machine room. -There was dust on the black fan in the dish machine room.Observation on 1/14/26 1:58 P.M., of dining room showed:-There was dried spilled residue all throughout the sitting area.-There was dried spilled residue next to the support column in the middle of the floor. During an interview on 1/14/26 at 2:00 P.M. the Executive Chef said:-Staff swept and mopped the kitchen every day. -Once a week staff deep clean, power wash the floors and pull the racks out of the cooler. -The holes in the walls and the drain cover should have been reported to maintenance in the tracking system.-The dining room should be swept and mopped after every meal.-Housekeeping would clean the dining room with a scrubber every other day. During an interview on 1/16/26 at 10:54 A.M. the House Keeping Supervisor said:-Dietary swept and mopped the dining room floors daily.-Once a week the house keeping staff would use the scrub machine on the dining room floor.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure Enhanced Barrier Precautions (EBP, infection control measures, primarily in long-term care, requiring gowns and gloves for all high-contact care activities for residents with multidrug-resistant organisms (MDROs), wounds, or indwelling devices, expanding beyond standard precautions to prevent transmission while allowing residents more freedom than contact precautions.) were implemented for two sampled residents (Resident #4 and #14) who were on EBP; failed to ensure handwashing was done after completing dirty tasks during resident care for two sampled residents (Resident #4 and #14); failed to ensure infection control practices to prevent cross-contamination with proper placement of medical devices to include suprapubic catheter (a urinary catheter that is inserted into the bladder from a small cut in your stomach, just above your pubic bone) drainage bag that was placed underneath a wheelchair was dragging on the floor, and failed to ensure Enhanced Barrier Precaution (EBP) performed to prevent cross contamination during incontinence care and treatment care for one sampled resident (Resident #7) who was at risk for Urinary Tack Infections (UTI - an infection of one or more structures in the urinary system) out of 21 sampled residents. The facility census was 105 residents. Review of the facility's Infection Control policy and procedure updated May 2024, showed This facility will facilitate safe care of all residents and staff with known or suspected communicable disease by establishing and maintaining an infection prevention and control program designed to pro- vide a safe, sanitary, and comfortable environment and to help pre- vent the development and transmission of communicable diseases and infections. This facility will follow Standard Precautions for Infection Control and Prevention to protect residents, staff and visitors to ensure staff do not carry infectious pathogens on hands or via equipment during resident care. The policy showed:-Contact precautions will be used to prevent transmission of pathogens that are spread by direct or indirect contact with the resident or environment and requires the use of appropriate personal protective equipment (PPE-gowns gloves goggles, facemasks) including a gown and gloves prior to or upon entering the room. Prior to leaving the resident's room, the PPE will be removed and hand hygiene performed.-This facility will follow the Enhanced Barrier Precautions Policy for all MDRO infections.-Personal Protective Equipment includes but is not limited to gloves, gowns, masks, goggles, if skin or clothing is likely to be exposed to blood or body fluids.-Certain PPE may be required when working in the facility, including the use of facemasks or eye protection during a respiratory virus pandemic including but not limited to gloves worn before and removed after contact with blood or body fluid, mucous membranes, or non-intact skin; gloves changed and hand hygiene performed before moving from a contaminated body site to a clean-body site during resident care; gown worn for direct resident contact if the resident has uncontained secretions or excretions or with contaminated or potentially contaminated items; appropriate mouth, nose, and eye protection is worn for resident care or procedures that are likely to contaminate mucous membranes, or generate splashes or sprays of blood, body fluids, secretions or excretions.-Donning PPE order-put on gown, then mask, then gloves. Ensure gown is secured behind neck and with tie behind back. PPE should be appropriately discarded after resident care prior to leaving room followed by hand hygiene.-Hand Hygiene refers to both washing with plain or anti-microbial soap and water and use of alcohol gel. When hands are not visibly soiled, alcohol gel is preferred method of hand hygiene.-Perform hand hygiene: Before and after contact with a resident, immediately after touching blood, body fluids, non-intact skin, mucous mem branes or contaminated items (even when gloves are worn during contact), Immediately after removing gloves, when moving from contaminated body sites to clean body sites during resident care, after touching objects and medical equipment in immediate resident care area. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility foley Catheterization of Urinary Bladder revised on April 2023 showed:-Hang collection bag (drainage bag) appropriately to the side of the bed and keeping the bag below the resident bladder and off the floor. 1. Review of Resident #14's Face Sheet showed the resident was admitted on [DATE] with diagnoses that included:-Cerebral Palsy (a permanent neurological disorder caused by damage to the developing brain, affecting movement, posture, and muscle coordination).-Aphasia (a language disorder resulting from brain damage that impairs the ability to understand or express spoken or written language).-Cancer.-Acid reflux.-Malnutrition.-Seizure disorder (a sudden burst of electrical activity in the brain, it can cause changes in behavior, movements, feelings and levels of consciousness).-Dysphagia (difficulty swallowing).-Gastrostomy tube (a flexible tube inserted through the abdominal wall directly into the stomach, creating a surgical opening (stoma) for delivering nutrition, fluids, and medicine when a person cannot eat or swallow properly, providing essential enteral feeding and hydration).-Urine retention.-Anemia (low iron levels).-Depression. Review of the resident's Care Plan updated 10/28/25, showed the resident was on EBP related to his/her gastrostomy tube. Interventions showed staff would:-Provide EBP as indicated.-Involved the use of PPE, specifically gowns and gloves during high contact resident care activities (prolonged resident care activities). Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated 10/31/25, showed the resident:-Was alert with cognitive incapacity.-Had impairment on both upper and lower extremities.-Needed total assistance for bathing, dressing, grooming, toileting, eating and mobility. Review of the resident's Physician's Order Sheet (POS) dated January 2026, showed:-An order for gastrostomy care and feeding. -The resident was on EBP due to his/her gastrostomy tube. Observation on 1/13/26 at 11:50 A.M., showed:-There was an EBP sign on the resident's door frame with a box containing PPE (gowns and gloves) in the hallway. -The resident was in bed awake and was watching tv. He/She was alert and oriented to self and was non-verbal. -Certified Nursing Assistant (CNA) F and Licensed Practical Nurse (LPN) C entered the resident's room without putting on a gown. -CNA F put on gloves without sanitizing his/her hands. -LPN C sanitized his/her hands then went to the resident and checked the placement of his/her gastrostomy tube by measuring the length with a ruler. He/She told CNA F he/she would come back after the resident's incontinence care was completed. -LPN C washed his/her hands, left the resident's room and sanitized his/her hands. -CNA F removed his/her gloves and left the resident's room without washing or sanitizing his/her hands. Observation on 1/13/25 at 11:59 A.M., showed:-CNA F entered the resident's room with supplies without putting on a gown or washing/sanitizing his/her hands. He/She sat the supplies down then left the resident's room to get gloves. -CNA F re-entered the resident's room and put on the gloves without handwashing/sanitizing his/her hands or putting on a gown, and began providing incontinence care, and cleaning the resident.-CNA F turned the resident to the side to complete cleaning the resident, rolled the soiled bed pad (which was under the resident) and his/her brief up, then without de-gloving, washing or sanitizing his/her hands, he/she took a clean pad and placed it under the resident, on top of the soiled bed pad. -The resident continued to use the bathroom, so CNA F removed his/her soiled gloves then without sanitizing or washing his/her hands, he/she re-gloved and used the call light to request assistance.-CNA G came into the resident's room with a gown and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gloves on. He/She held the resident to the side while CNA F cleaned the resident's bottom again. When he/she finished, he/she rolled the soiled pad, and sheet up against the resident's bottom. CNA F then removed his/her gloves and without washing or sanitizing his/her hands, he/she left the resident's room. -CNA F re-entered the resident's room with clean linen, without wearing a gown, or washing/sanitizing his/her hands, put on gloves and put the clean sheet and bed pad on the bed under the resident. CNA F and CNA G both rolled the resident over to his/her opposite side and CNA G removed the soiled linen from under the resident. -CNA F and CNA G both finished cleaning the resident's bottom before rolling the resident onto the clean pad.-Without removing gloves and washing/sanitizing their hands, CNA F and CNA G put the resident's clean brief on. -CNA G then placed the soiled linen in a trash bag, removed his/her gloves and washed his/her hands. -CNA F then put the resident's gown on, then removed his/her gloves and washed his/her hands. -CNA F and CNA G both re-gloved and repositioned the resident in bed and made the resident comfortable. CNA G then de-gloved, de-gowned and washed his/her hands. -CNA F pulled the resident's trash, de-gloved and then exited the resident's room without washing his/her hands. During an interview on 1/13/26 at 12:22 P.M., CNA G said:-The resident had an EBP sign on his/her door, and so he/she was supposed to wear a gown upon entering his/her room.-He/She did not know which resident was on EBP so it was better to wear the gown than not to. During an interview on 1/13/26 at 12:25 P.M. CNA F said:-The EBP protocol was, if there was an EBP sign on the door, they were to put on the gown with gloves prior to entering the room.-He/She did not know why or that the resident was on EBP and he/she had not initially looked at the door to see the sign.-Regarding handwashing, he/she was supposed to change gloves and wash his/her hands during incontinence care when changing to another part of the body, before he/she touched anything else in the resident's room, before he/she left the resident's room and whenever he/she went from a dirty task to a clean task. -He/She did not wash or sanitize between the dirty and clean tasks because he/she was moving fast and was a little frustrated that the resident began using the bathroom again after he/she had cleaned the resident up. Observation on 1/13/26 at 12:29 P.M., showed:-LPN Z came into the resident's room without putting on a gown. He/She washed his/her hands, gloved and informed resident that he/she was going to feed him/her via his/her gastrostomy tube. -LPN Z measured the resident's gastrostomy tube and checked placement and residual fluid prior to feeding the resident. After feeding the resident he/she rinsed the supplies, de-gloved and washed his/her hands. During an interview on 1/13/26 at 12:30 P.M. LPN Z said:-He/She did not gown because he/she did not know the resident was on EBP. -When a resident was on EBP, all nursing staff were supposed to sanitize/wash their hands, gown and glove prior to or upon entering the resident's room. -He/She had not paid close attention to the identifier on the resident's door. -He/She had taken care of the resident since he/she was admitted to the facility and did not know that he/she was supposed to be on EBP. During an interview on 1/16/26 at 12:04 P.M., the Chief Nursing Officer (CNO) said:-EBP should be worn with a resident who had a feeding tube.-A gown should have been worn while providing care to a resident with a feeding tube.-Hand hygiene should be completed between clean and dirty processes and between glove changes. 2. Review of Resident #4's Face Sheet showed the resident was admitted on [DATE], with diagnoses that included:-Diabetes (a chronic, metabolic disease characterized by elevated levels of blood glucose (or blood sugar).-Anemia (a condition that develops when your blood produces a (continued on next page)

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	265303	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Carondelet LLC	621 Carondelet Drive Kansas City, MO 64114

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	lower-than-normal amount of healthy red blood cells)-Atrial fibrillation (AFib is an irregular and often very rapid heart rhythm).-Kidney failure.-Seizures.-Cholecystitis (inflammation of the gallbladder),-Prostatic hyperplasia (enlargement of the prostate gland causing urinary problems like frequent urination). Review of the resident's Care Plan updated 11/4/25, showed the resident was on EBP for wounds, a urinary catheter and nephrostomy tube. Interventions showed staff was to:-Provide EBP as indicated.-Involved the use of PPE, specifically gowns and gloves during high contact resident care activities (prolonged, direct contact). Review of the resident's annual MDS dated [DATE], showed the resident:-Was alert and oriented with some cognitive loss.-Was dependent on staff for bathing, dressing, toileting, eating and mobility.-Had a urinary catheter (a thin, flexible tube inserted into the bladder to drain urine out of the body). Review of the resident's POS dated January 2026, showed:-Physician's orders for wound care, catheter care and nephrostomy care. -The resident was on enhanced barrier precautions for wound care. Observation on 1/13/26 at 11:33 A.M., showed:-There was an EBP sign on the resident's door frame with a box containing PPE (containing gowns and gloves) in the hallway. -The resident was in bed awake without odors. -The resident's catheter collection bag was at the side of his/her bed below his/her bladder and his/her nephrostomy bag (a surgical opening from the kidney's urine-collecting area (renal pelvis) directly to the skin, usually in the back, to allow urine to drain externally via a tube (nephrostomy tube) into a bag, bypassing a blockage from kidney stones, tumors, or injury and preventing kidney damage) was laying on his/her bed with minimal fluid in it and in the tubing. During an interview on 1/13/26 at 11:33 A.M. the resident said:-He/She was doing well and had no issues regarding staff care and services. -He/She did not recall if the staff wore gowns when providing care. -He/She was satisfied with his/her care. During an observation on 1/13/26 at 11:35 A.M. showed the resident:-Pulled his/her call light and CNA F responded and asked the resident what he/she needed. The resident requested to be re-positioned in bed on his/her side. CNA F exited the resident's room and obtained gloves from the box of gloves that was on the railing in the hallway. CNA F then, without sanitizing his/her hands or putting on a gown, gloved then re-entered the resident's room and began repositioning the resident. When he/she was done, he/she removed his/her gloves and without sanitizing or washing his/her hands, CNA F exited the resident's room. During an interview on 1/13/26 at 11:37 A.M. CNA F said:-He/She was supposed to wear a gown with residents who were on EBP.-He/She did not normally work that hall and did not know all the residents who were on EBP.-He/She did not know the resident was on EBP.-He/She was supposed to wash or sanitize his/her hands upon entering the resident's room prior to putting on gloves and upon leaving after removing his/her gloves. During an interview on 1/16/25 at 12:40 P.M., the CNO said he/she expected the nursing staff to follow EBP protocol whenever providing direct care to residents who were on EBP. 3. Review of Resident #7's admission Record Sheet showed he/she admitted with the following diagnoses: -Malignant Neoplasm of the bladder (cancer of bladder). -Retention of Urine (is when your (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bladder doesn't empty completely or at all). Review of the resident suprapubic Care plan revised on 10/5/25 showed:-Check placement of the tubing each shift. -Provide Enhanced Barrier Precautions as indicated. Involved the use of PPE, specifically gowns and gloves, during high contact resident care activities (i.e., prolonged direct contact) revised on 7/23/25.-The resident had a suprapubic urinary catheter related to Obstructive and reflux of uropathy (is a condition in which the flow of urine is blocked).-Monitor, record and report to the physician any signs and symptoms of urinary infection. Review of the resident's Quarterly MDS dated [DATE], showed he/she:-Was cognitively intact.-Was able to understand others and make his/her needs known.-Required total assistance from staff for toileting.-Was admitted with an indwelling catheter. Review of the resident's POS dated 12/1/25 showed:-He/she was on EBP for an indwelling catheter every shift, dated 10/31/24.-Nursing staff were to provide indwelling catheter care every shift, dated 10/8/25.-Nursing staff were to change the Suprapubic catheter (use an 18 French Fr, a measurement of the outer diameter of a catheter), change every month at bedtime starting on the 6th and ending every month on the 7th, dated 12/6/25. -Monitor the Suprapubic catheter site for signs and symptoms of infection, including redness, drainage, and swelling every shift for new Suprapubic catheter site. Was dated 4/2/25. Observation on 1/12/26 at 11:21 A.M., of the resident showed. -He/She was sitting in a wheelchair in the hallway close to the nursing station. -An unknown nurse was standing next to the medication cart administrating medication to the resident. -The resident's catheter drainage bag and part of the tubing was dragging on the ground underneath his/her wheelchair.-The catheter tubing had a thick yellow substance in drainage tube. Observation on 1/14/26 at 12:00 P.M. of the resident showed: -He/she was sitting in a wheelchair in the hallway. -The catheter drainage bag was under his/her wheelchair and was dragging on the ground. Observation on 1/15/26 at 9:45 A.M. of the resident's Suprapubic catheter care showed: -The resident did not have Enhanced Barrier Precaution signage posted on the outside of his/her room door frame -CNA C entered the resident's room and sanitized his/her hands then placed gloves on his/her hands. -CNA C did not apply a gown or mask. -CNA C emptied the resident's catheter drainage bag of clear yellow urine into a graduate container. -CNA C provided incontinent care for the resident after he/she changed gloves. -CNA C did not wear PPE of a gown or mask while draining the catheter drainage bag of urine and during personal incontinent care for the resident. During an interview on 1/15/2026 12:14 P.M., CNA C said:-The CNA's completed incontinent care and emptied the resident's catheter drainage bag.-The resident's catheter drainage bag should be placed underneath the wheelchair secure, so it was not touching or dragging on the ground.-If the catheter drainage bag was found on the ground, he/she would clean the drainage bag with bleach wipes and then reposition the drainage bag so it was not touching the ground. -He/she was not aware the resident was on EBP.-If a resident was on EBP staff should wear a gown, gloves and mask when they provided direct contact care such as incontinence care and emptying the catheter drainage bag. During an interview on 1/16/26 at 9:11 A.M., CNA D said:-The resident's catheter bag should be secure underneath his/her wheelchair and should not be dragging on the ground. -The resident was on (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	EBP and the CNA who provided any direct care should wear a gown, gloves and mask during the direct care process. During an interview on 1/16/2026 at 9:31 A.M., LPN B said:-The resident's catheter drainage bag should be placed securely underneath the resident's wheelchair and should never be touching the ground.-If found on the ground then the catheter drainage bag needed to be cleaned or replaced. -The resident should be on EBP due to the Suprapubic catheter. He/she would expect EBP signage on the door frame of the resident's room. -All staff were required to wear a gown, gloves and mask during any direct care provided for the resident. During an interview on 1/16/26 at 10:35 A.M., with Infection Control Preventionist (ICP) and the [NAME] President of Clinical Operations (VPCO) said: -He/she would be responsible to ensure infection precaution signage was posted on the resident's door and door frame with the type of precaution the resident was on. -Would expect a resident with a Suprapubic catheter be placed on EBP and staff should wear PPE of gown, gloves and mask if case splatter during any direct care provided. -The resident's catheter drainage bag should be secure and placed so it did not drag or touch the ground. -He/she would expect all care staff to preform hand hygiene before and after resident care, between a dirty to clean process, and between each glove changes. During an interview on 1/16/26 at 12:04 P.M., the CNO said: -He/she would expect care staff to perform hand hygiene upon entering and exiting a resident room, from a dirty to clean process, and between each glove change. -The resident's catheter drainage bag should be secured under the wheelchair and not dragging on the ground.-If found dragging on ground he/she would expect care staff to change the dirty drainage bag and with clean drainage bag. -He/she would expect EBP signage to be posted by the ICP for those residents at risk. -The resident was to be on EBP. -He/she would expect care staff to apply a gown, gloves and mask for any direct care provided including incontinent care and catheter care.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to maintain the inner area of the climate control units in resident rooms A9, A1, B11, D3, free from debris; failed to ensure the restroom ceiling vent covers in the restrooms of resident rooms A14, C8, C3, and D11, were firmly attached to the ceiling; failed to ensure the hand rail in the restroom of resident room A5, was firmly attached to the wall; and failed to ensure the wall guard in C12 was firmly attached to the wall. This practice potentially affected at least 15 residents who resided in or used those areas. The facility census was 105 residents. 1. Observation on 1/13/26 between 11:02 A.M. and 2:41 P.M., with the Facility Maintenance Director of the climate control units, showed:-The presence of an ointment bottle, a fork and a small medication cup were inside the climate control unit in resident room A9, with the grate cover for the climate control unit missing.-There was a heavy buildup of dust and cobwebs in the climate control unit in resident room A1.-There was a heavy buildup of dust and cobwebs in the climate control unit in resident room B11.-There was a large amount of dust and debris inside of the climate control unit in resident room D3.During an interview on 1/14/26 at 11:10 A.M., the Facility Maintenance Director said the climate control units should be checked once per month for debris buildup.2. Observation on 1/13/26 between 10:56 A.M. and 2:25 P.M., with the Facility Maintenance Director of the restroom ceiling vents, showed:-The ceiling vent in the restroom of resident room A14 was loose and not firmly attached to the ceiling.-The ceiling vent in the restroom of resident room C8 was loose and not firmly attached to the ceiling.-The ceiling vent in the restroom of resident room C3 was absent from the ceiling.-The ceiling vent in the restroom of resident room D11 was loose and not firmly attached to the ceiling.During an interview on 1/14/26 at 11:08 A.M. the Facility Maintenance Director said he/she had checked those vents in the past.3. Observation on 1/11/26 at 3:15 P.M.; 1/13/26 at 9:20 A.M., and on 1/13/26 at 12:51 P.M., showed a handrail that was not firmly attached to the wall of the restroom in resident room A5.4. Observation on 1/14/26 at 11:31 A.M. showed the wall guard in resident room C12 was peeling away from the wall with some of the screws protruding from the guard as it was detached from the wall.During an interview on 1/14/26 at 11:31 A.M., the Facility Maintenance Director said:-He/She was unaware of the loose wall guard in resident room C12.-He/She thought the facility staff (nurses and housekeepers) were really good about placing those items in The Equipment Lifecycle System (TELS(R)--Platform connects your teams to the data that matters - work orders, assets, compliance, and capital planning - all in one place).2685006

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have enough outside ventilation via a window or mechanical ventilation, or both. Based on observation and interview, the facility failed to ensure there was negative airflow in the restrooms of the following resident rooms H7, H6, H5, H4, H2, H1, G8, G5, G7, G9, G12, G14, D8, D7, D4, D5, D3, D2, and D1. This practice potentially affected 23 residents who resided in those rooms. The facility census was 105 residents. *Note: Air flow was tested by holding one piece of tissue paper to the ceiling vent. If the paper was drawn to the vent, then negative air flow was present; if the paper fell, then negative airflow was absent. 1. Observation on 1/12/26, with the Facility Maintenance Director and the Senior [NAME] President of Facility Services showed the following:-At 2:31 P.M. there was the absence of negative air flow in the restroom of resident room H7.-At 2:33 P.M. there was the absence of negative airflow in the restroom of resident room H6.-At 2:36 P.M. there was the absence of negative airflow in in the restroom of resident room H5.-At 2:38 P.M. there was the absence of negative airflow in the restroom of resident room H4.-At 2:39 P.M. there was the absence of negative airflow in the restroom of resident room H2.-At 2:44 P.M. there was the absence of negative airflow in the restroom of resident room H1.Observation on 1/13/26, with the Facility Maintenance Director and the Senior [NAME] President of Facility Services showed the following:-At 9:02 A.M. there was the absence of negative airflow in the restroom of resident room G6.-At 9:04 A.M. there was the absence of negative airflow in the restroom of resident room G8.-At 9:06 A.M. there was the absence of negative airflow in the restroom of resident room G5.-At 9:08 A.M. there was the absence of negative airflow in the restroom of resident room G7.-At 9:23 A.M. there was the absence of negative airflow in the restroom of resident room G9.-At 9:25 A.M. there was the absence of negative airflow in the restroom of resident room G12.-At 9:27 A.M. there was the absence of negative airflow in the restroom of resident room G14.-At 2:25 P.M. there was the absence of negative airflow in the restroom of resident room D8.-At 2:32 P.M. there was the absence of negative airflow in the restroom of resident room D7.-At 2:35 P.M. there was the absence of negative airflow in the restroom of resident room D4.-At 2:38 P.M. there was the absence of negative airflow in the restroom of resident room D5.-At 2:41 P.M. there was the absence of negative airflow in the restroom of resident room D3.-At 2:44 P.M. there was the absence of negative airflow in the restroom of resident room D2. -At 2:47 P.M., there was the absence of negative airflow in the restroom of resident room D1.During an interview on 1/14/26 at 11:01 A.M., the Facility Maintenance Director said:-He/She had not checked for negative airflow since he/she started.-He/She was not told to check for negative airflow in the resident rooms.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to meet professional standards of practice when administering insulin (a hormone that regulates blood sugar), without cleansing the insulin pen rubber septum with alcohol prior to applying the pen needle and injecting insulin for two supplemental residents (Resident #75 and #115) out of 6 supplemental residents. The facility census was 105 residents. Review of the facility's Injections Policy last reviewed/revised in May 2023 showed there was no instruction given to clean pen septum prior to drawing up insulin.1. Review of Resident #75's face sheet showed he/she was admitted to the facility on [DATE] with a diagnosis of Diabetes Mellitus (DM a complex disorder of carbohydrate, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of insulin secretion in the pancreas or resistance to insulin).Review of the resident's Physician's Order Sheet (POS) showed:-Humalog (a fast-acting insulin used to control high blood sugar) 20 units every day before meals.Observation on 1/14/26 at 11:58 A.M., showed:-Licensed Practical Nurse (LPN) F applied needle, drew up insulin, discarded due to wrong amount drawn, removed needle, did not wipe pen septum with alcohol, replaced needle, primed insulin and drew up 20 units of insulin.2. Review of Resident #115's face sheet showed he/she was admitted to the facility on [DATE] with a diagnosis of Diabetes Mellitus.Review of the resident's POS showed:- Novolog (a rapid acting prescription insulin used to control high blood sugar) FlexPen 100 UNIT/milliliter (ML) Solution pen-injector--Inject as per sliding scale: if 0 - 150 = 0 units; 151 - 200 = 2 units; 201 - 250 = 3 units; 251 - 300 = 4 units; 301 - 350 = 5 units; 351 - 400 = 6 units Greater than 400 give and notify MD; notify provider for less than 70 , subcutaneously before meals and at bedtime for Diabetes Mellitus.- Lantus (a long-acting insulin used to control high blood sugar) SoloStar 100 UNIT/ML Solution pen-injector--Inject 10 units subcutaneously two times a day for DM; Hold if blood glucose less than 60, give and notify provider if greater than 400.Observation on 1/15/26 at 8:28 A.M., showed LPN D did not clean the Novolog or Lantus insulin pen septum with alcohol prior to applying pen needle, priming and drawing up medicine.3. During an interview on 1/15/26 at 9:02 A.M., LPN D said:-The facility policy on infection control when injecting insulin was to clean the resident's skin with alcohol, check skin, wipe insulin pen with alcohol and then apply needle.-Insulin pens should be wiped with alcohol prior to applying the needle and injecting into the resident.-Contamination risk could have been prevented when using the insulin pens by performing hand hygiene, applying any appropriate Personal Protective Equipment (PPE) such as gloves, and wiping all insulin injection pens and the resident's skin with alcohol. -The risk of not cleaning the insulin pens with alcohol prior to use is anywhere from minor to severe infection.During an interview on 1/15/26 at 9:51 A.M. the Chief Nursing Officer (CNO) said:-The facility policy for using insulin pens was to wipe the pen with alcohol before attaching the needle and cleanse the site with alcohol prior to administration.-He/She would expect nurses to clean the insulin pens with alcohol prior to attaching the pen needle.-Contamination was prevented with injector pens by swabbing the pen and skin with alcohol prior to administration.-The risks of not doing this could result in bacteria being passed or cross contamination and can range from mild to severe.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure multiple shower refusals were reviewed and documented for a potential reason for the shower refusals, and failed to review and document preferences for bathing or shower days and preferred shower times, for one sampled resident (Resident's #19), who refused 5 out 5 showers since his/her admission; and failed to ensure one sampled resident (Resident #12) who required staff assistance with activities of daily living (ADL's) had the call light placed within his/her reach out of 21 sampled residents. The facility resident census of 105 residents. The facility's Bathing/Shower Program policy was requested and not received at time of exit. Review of the facility's Call Light-Ability to Use policy last revised/reviewed in January 2024, showed:-The call light system is provided as a tool for residents to communicate with staff.-Residents will be evaluated for ability to use call light on admission, quarterly and annually.-If residents are determined to be physically unable to use call lights, alternative call buttons (touch, whistle, etc.) will be provided.-Staff members will ensure that call lights are within reach of a resident who is able to cognitively use a call light each time they leave the room. 1.Review of Resident #19's admission Record showed he/she was admitted on [DATE] with a diagnosis of adult failure to thrive (a decline in older adults that manifests as a downward spiral of health and ability) and need for assistance with personal cares. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 12/3/25 showed he/she:-Was cognitively intact.-Was able to understand others and make his/her needs known. Review of the facility's binder that indicated the resident's assigned shower days and time schedule dated 7/21/25 showed:-Residents were assigned their showers by room number.-The resident's room was assigned for a shower during the evening/night shift on Monday and Thursday.-A note on the binder indicated the Certified Nursing Assistant's (CNA's) were to report any skin changes and refusal of showers to the charge nurse. If a resident refused a shower, the CNA would document on the resident's shower sheet the resident had refused a shower. The shower sheet was to be signed by the resident or guest for any refusal of shower for assigned shower times and day. Review of the resident's Care Plan for ADL's dated 12/4/25 showed:-He/She had ADL self-care performance deficits, needed assistance with cares, required assistance with shower or bathing. -The resident had delirium (a sudden, serious change in mental state, causing confusion, disorientation, and reduced awareness, with symptoms like difficulty focusing, memory problems, hallucinations, agitation, or drowsiness, often fluctuating over hours or days, and typically linked to an underlying medical issue, infection, medication, or substance withdrawal).-The resident had delusions (a fixed, false belief held with strong conviction despite evidence to the contrary, not shared by the person's culture, and often involving misinterpretations of reality).-Known noncompliance with medical treatment. Review of resident's Skin monitoring: CNA shower Review sheet forms dated 12/8/25 to 12/31/25 showed:-The resident was offered showers during evening/night shift as assigned by room number. -On 12/8/25 he/she refused the shower as it was too late to take shower: and was signed by the resident. will shower next time. -On 12/11/25 he/she refused the shower and indicated he/she liked (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	taking showers in the morning and the shower sheet was signed by the resident. -On 12/15/25 he/she refused a shower, and the shower sheet was signed by the resident.-On 12/18/25 the resident refused a shower, the shower sheet did not have the resident's signature for refusal of the shower. -On 12/23/25 the resident was in hospital. -There was no documentation on the shower sheet that the refusal of the shower had been addressed or the resident had been educated by the licensed nurse for noncompliance. Review of the resident's medical record dated 12/8/25 to 12/31/25 showed:-There was no documentation related to the residents refusal of his/her evening shift shower.-There was no documentation of any new interventions put in place related to bathing preferences and refusal of shower on the evening shift. Review of the resident's Care Plan dated 12/19/25 showed:-The resident was resistive to care, refusing care and medication and treatments.-Interventions included:--Encourage the resident to comply with cares.--Educate the resident and family, inform family member and the resident of outcomes from not complying with recommended treatment and cares.--Give clear explanation of all care activities prior to and as they occur during each contact with the resident. Review of the resident's care plan dated 12/30/25 showed:-History of refusal of care, treatments and medications. -There were no new interventions that indicated new approaches to encourage taking showers.-There were no new interventions that indicated the facility had offered to change his/her shower day and time to match his/her preference. Review of resident's Skin Monitoring: CNA Shower Review Sheets dated 1/1/26 to 1/8/26 showed:-The resident was assigned to evening/night shift for showers.-On 1/1/26 and on 1/5/26 no shower was given due to resident being in the hospital. -On 1/8/26 there was documentation the resident had refused a shower during the evening shift. --There was no resident signature for refusal of the shower. --There was no documentation on the shower sheet that the refusal of the shower had been addressed, or the resident had been educated by the licensed nurse for potential outcomes of noncompliance with bathing. Review of the resident's medical record dated 1/1/26 to 1/10/26 showed:-There was no documentation related to the resident's refusal of the evening shift shower.-There was no documentation of any new interventions put in place related to bathing preferences. Review of the resident's nurse Health Status Note dated 1/11/26 at 6:46 P.M., showed nursing reported to the Chief Nursing Officer (CNO) about the resident refusing showers on the assigned days and time. Observation on 1/12/26 at 3:22 P.M., of the resident showed: -There were no lingering odors noted in the resident's room. -The resident was clean, and he/she denied any care issues at that time. During an interview on 1/15/26 at 12:00 P.M., the resident said:-He/she had received a shower on Tuesday when his/her daughter was at the facility. -He/she was not aware he/she was assigned certain shower days and time. -He/she had wash cloths and towels available in his/her room to provide sponge baths at the bathroom sink. Review of the resident's Health Status Note dated 1/13/26 at 1:17 P.M. showed:-Staff called and spoke with the family regarding the resident ongoing refusal of showers and challenges with (continued on next page)

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	265303	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Carondelet LLC	621 Carondelet Drive Kansas City, MO 64114

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bathing.-The resident was referred to Social Services and Psychiatric Services. Review of the resident's Social Services note dated 1/14/26 at 5:56 P.M., showed: -Social Services called to talk to the resident's family member about setting up a care plan meeting. -The family member said he/she had been helping the resident with showers. -The family member preferred to help the resident with showers. -He/she didn't want the resident to refuse showers from care staff. -The family member would talk to the resident about allowing staff to provide care also. During an interview on 1/15/26 at 12:14 P.M., CNA C said:-If the resident refused a shower he/she would offer again later that shift, then notify the charge nurse the resident had refused.-He/She would have the resident sign the shower sheet.-The resident was assigned to the evening night shift for showers. During an interview on 1/16/26 at 9:11 A.M., CNA D said: -The resident was scheduled for nights shift showers. -Day shift showers did not populate as an option for the resident on the resident care task.-The resident's family member would give the resident baths also. -If the resident refused a shower or care, he/she would let the charge nurse know and the nurse would follow-up with the resident on why refused. During an interview on 1/16/26 at 9:31 A.M., Licensed Practical Nurse (LPN) B said:-For a shower refusal, the staff would try to offer a shower later that shift after first refusal, then if refused second time would then ask the resident why and would have the resident sign that he/she had refused the shower.-Nurse would let management know so they could follow-up with family members to encourage the resident to shower. -Nursing management would be responsible for changing the resident's shower days. -It was discussed during morning clinical meeting that the resident preferred a different time or days. -The resident was able to and provided some of his/her own personal body care at the bathroom sink, provided own sponge bath.-The night nurse would be responsible to document the resident refusal of a shower and any follow-up action taken. -He/she had not seen the resident unclean in the morning shift change. During an interview on 1/16/26 at 12:04 P.M., CNO said: -The resident had a history of refusal of cares by staff to include night/evening showers.-The resident's shower days and times were assigned by their room number.-Shower sheets were to be reviewed by the charge nurse every shift. -The resident care plan meeting reviewed the resident's preference on showering and then determined if there was a need to change the shower schedule.-The resident's shower should be documented by the assigned CNA as given or refused. -If a resident refused a shower he/she would expect the CNA to document on the shower sheet refused and have the resident sign that he/she had refused the shower that day. -If staff noted ongoing refusal of showers, then he/she would expect the CNA to notify the charge nurse to address with the resident and discuss the refusal of the showers with care team during the morning clinical meetings. -The resident's family member expressed concern related to the resident refusing staff assistance with his/her showers. The family indicated they would like to provide the resident shower when they visited. -He/she would expect shower/bathing provided by a family member be documented on the resident's shower sheet and/or in the nursing progress notes. -The clinical administrative staff were more focused on the resident's mental health changes and physical changes, then they were going to address the resident's refusal of care and his/her care preferences. 2. Review of Resident #12's admission Face Sheet showed he/she was admitted to the facility with diagnoses that included:-Dementia (a progressive organic mental disorder characterized by chronic (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment, and impulses).-Muscle weakness.-Need for assistance with personal care.-Difficulty walking. Review of the resident's Quarterly MDS dated [DATE] showed the resident:-Was able to express ideas and wants.-Had the ability to understand others.-Was moderately cognitively impaired.-Required either moderate or maximal assistance with self-care.-Required either moderate or maximal assistance with transfers, mobility, and walking up to 10 feet.-Had a diagnosis of Dementia.-Had a history of falls. Observation on 1/11/26 at 2:22 P.M., showed:-The resident was in bed.-The resident's call light was behind his/her nightstand and not within reach. Observation on 1/12/16 at 3:34 P.M., showed:-The resident was in bed.-The resident's call light was draped over the back of his/her nightstand and not within reach. During an interview on 1/12/26 at 3:24 P.M., the resident said:-Staff kept him/her in bed most of the time due to frequent falls.-The night shift staff purposefully placed his/her out of reach during the shift.-He/She was not able to get up on his/her own to go to the bathroom because he/she could not walk very far and had to wait until staff came into the room to check on him/her. Observation on 1/13/26 at 9:32 A.M., showed:-The resident was in his/her wheelchair in his/her room.-The resident's call light was behind his/her nightstand and not within reach. Observation on 1/13/26 at 10:03 A.M., showed the Assistant Chief Nursing Officer (ACNO):-Completed wound care and incontinent care on the resident.-The resident chose to stay in bed when asked.-The call light was not placed within reach. Observation on 1/14/26 at 8:17 A.M., showed:-The resident was in his/her wheelchair in his/her room.-The resident's call light was behind his/her nightstand and not within reach. Review of the resident's care plan last updated on 1/14/26 showed:-He/She had a communication problem related to difficulty understanding and expressing self at times.--Staff were to ensure/provide a safe environment by having the call light within reach.-He/She had an ADL self-care performance deficit and limited physical mobility related to Dementia, limited range of motion, and generalized weakness.--Staff were to encourage the resident to use the call light for assistance.--Staff were to educate the resident on the need to call for assistance when transferring, ensure the resident's call light was within reach and encourage him/her to use it. Observation on 1/14/26 at 11:41 A.M., showed:-The resident was in bed sleeping in his/her room.-The resident's call light was behind his/her nightstand and not within reach. During an interview on 1/16/26 at 10:12 A.M., CNA E said:-The resident required assistance from staff with cares and transfers.-He/She knew what the resident's assistance needs were based on information at the nurse's station and by asking the nurse.-He/She knew when the resident needed assistance by doing rounds and when the resident used the call light because he/she can use it.-He/She made sure the call light was within reach by making sure it was close by the resident and telling him/her that it was there.-Call lights were checked every time they entered the room and during rounds.-All nursing and other staff were responsible for making sure that call lights were (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	within reach after cares had been provided.-Call lights should be placed within reach by being hooked to the bed or linens.-If a call light was found to be out of reach, he/she should place it within the resident's reach as soon as possible.-Staff should ensure call lights were within reach before leaving the room.-He/She identified the resident's call light was behind his/her nightstand.-The call light should not have been behind the nightstand. During an interview on 1/16/26 at 11:11 A.M., LPN C said:-The resident required assistance from staff with cares and transfers.-He/She knew what assistance was needed for the resident by looking at the resident's Electronic Health Record (EHR) under therapy, task, and MDS tabs and under the progress notes.-He/She would know if the resident was in need of assistance because he/she usually yelled out or using the call light.-The CNA's would check under interventions in the resident's EHR or ask the nurse to find out what assistance a resident needed.-Call lights should be checked when going in and coming out of the resident's room.-Everyone was responsible for making sure that call lights were within reach at all times.-All nursing staff was responsible for implementing the resident's interventions.-Call lights should be within reach before leaving the room by attaching it to the linens or bed rail in a position where the resident could reach it.-He/She attended an in-service one week ago that included the topics of call light placement.-Risks for not having the call light within reach at all times were fall and injury. During an interview on 1/16/26 at 12:05 P.M., the CNO said:-He/She would expect the resident's call light to always be within reach.-All nursing staff were responsible for making sure that call lights were within reach.-Staff should check that call lights were within reach before leaving a resident's room.-If staff saw a call light was not within reach, he/she would expect staff to place it within reach by securing it to the linens or wrap it around the bed rail.-He/She would expect the resident's care plan to be followed and interventions implemented.-Staff could find information about the resident's assistance needs and intervention information in the Kardex (a quick reference tool in the resident chart that has summarizes resident data a such as medications, care plans and critical information), care plan, during wound rounds and orders.-He/She would expect residents who are dependent on staff for all care and transfers to have their call light within reach at all times. -Staff received training on call light accessibility every month during an in-service, during new employee orientation and as needed. Complaint # 2703939

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one sampled resident (Resident #93) had access to an adaptive call light device and that the call light was within reach; and failed to implement ordered pressure injury prevention interventions, including the application of Prevalon boots while in bed. This failure placed the resident at risk for unmet needs, delayed assistance, and increased risk for pressure injury development out of 21 sampled residents. The facility census was 105 residents. Review of the facility's Call Light-Ability to Use policy revised January 2024 showed:-The call light system was provided as a tool for residents to communicate with staff.-Residents would be evaluated for ability to use call light on admission, quarterly and annually.-If residents are determined to be physically unable to use call lights, alternative call buttons (touch, whistle, etc.) would be provided.-If residents are determined to be cognitively unable to use call lights, residents will be monitored for needs by staff members during rounds and while delivering care.-Staff members would ensure that call lights are within reach of a resident who is able to cognitively use a call light each time they leave the room.Review of the facility's ADL (Activities of Daily Living) policy revised April 2023 showed:-The facility would provide each resident with care, treatment and services according to the resident's individualized care plan. -Based on the individual resident's comprehensive assessment, facility staff would ensure that each resident's abilities in activities in activities of daily living do not diminish unless circumstances of the resident's clinical condition demonstrated that the decline was unavoidable, including:--Communication including using speech, language or other functional communication systems specific to the needs of the individual resident.Review of the facility's Physician Orders policy revised May 2023 showed:-Orders may be called, hand-written, faxed, or electronically generated by physician.-The physician's order must be documented completely with sufficient content to clearly convey.-Orders that are unclear must be clarified prior to implementation.Review of the facility's Statement of Resident Rights dated June 2013 showed the resident:-Had the right to receive the services specified in the service plan.-Had the right to be free of neglect.1. Review of Resident #93's Face Sheet showed he/she was admitted on [DATE] with diagnoses that included:-Protein-calorie malnutrition (lack of proper nutrition, caused by not having enough to eat, not eating enough of the right things, or being unable to use the food that one does eat).- Palliative Care (specialized medical support focused on relieving symptoms and stress from serious illnesses).-Cognitive communication deficit.-Difficulty in walking.-Legal blindness.-Senile Degeneration of Brain (age-related cognitive decline, now typically called dementia characterized by progressive loss of memory, thinking, and daily function).-Type 2 Diabetes Mellitus (a complex disorder of carbohydrate, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of insulin secretion in the pancreas or resistance to insulin).Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated December 2025 showed the resident:-Had some difficulty communicating some words or finishing thoughts.-Usually understood others but missed some part/intent of message.-Had severely impaired vision.-Was severely cognitively impaired.-Was completely dependent for all ADL's.-Was completely dependent for all transfers and changes in position.-Was incontinent of bowel and bladder.-Was at risk of developing pressure ulcer/injury.Review of the resident's Physician Order Sheet (POS) dated January 2026 showed a physician's order for Prevalon boots to be worn when in bed.Review of the resident's Care Plan dated January 2026 showed:-Resident was vision impaired and legally blind. Interventions showed staff would:--Keep call light and other key items within reach.--Tell resident where items were placed, be consistent.-Resident had self-care deficits related to chronic health conditions, significant changes in ability to participate, recent hospice (a specialized, holistic, and compassionate form of end-of-life care focused on providing comfort, dignity, and quality of life rather than curative treatment for (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	patients with a terminal prognosis of six months or less) admission for senile degeneration of brain. Interventions showed staff would:--Encourage the resident to use bell to call for assistance.-Resident was at risk for falls related to conditions, reduced function, legally blind and recent falls. Interventions showed staff would:--Ensure the resident's call light was within reach and encourage the resident to use it for assistance as needed. The resident needed prompt response to all requests for assistance, initiated on 5/1/23.--Provide soft touch call light for resident use, initiated on 6/23/23.-Resident had risk for impaired skin integrity related to immobility and incontinence. Interventions showed staff would:--Apply bunny boots to bilateral feet for pressure relief, initiated 6/27/23.Observation on 1/11/26 at 3:52 A.M. showed the resident:-Was in bed resting with no Prevalon boots applied.-The standard call light was on the floor between the bed and nightstand and not within the resident's reach. -There was no adaptive call light present.Observation on 1/12/26 at 12:11 P.M. showed the resident:-Was in bed sleeping with no Prevalon boots applied.-The standard call light was tied to the lower bed frame and not within the resident's reach. -There was no adaptive call light present.Observation on 1/13/26 at 12:04 P.M. showed the resident:-Was in bed resting with no Prevalon boots applied.-The standard call light was tied to the lower bed frame and not within the resident's reach.-There was no adaptive call light present.Observation on 1/14/26 at 8:24 A.M. showed the resident:-Was in bed sleeping with no Prevalon boots applied.-The standard call light was tied to the lower bed frame and not within the resident's reach.-There was no adaptive call light present.Observation on 1/16/26 at 9:15 A.M. showed the resident:-Was in bed resting with no Prevalon boots applied.-The standard call light was tied to the lower bed frame and not within the resident's reach.-There was no adaptive call light present.During an interview on 1/16/26 at 11:00 A.M., Certified Nursing Assistant (CNA) H said:-The resident had limitations with mobility and positioning and required total assistance from staff.-He/she knew what the resident's interventions for cares and assistance were because he/she had been taking care of the resident for a long time and just knew.-He/she could find this information in the resident's electronic medical record or by asking the charge nurse.-He/she would know if the resident needed assistance by the call light being activated and by randomly doing rounds.-The call light should always be within reach and attached to the siderail, bed linens or the resident's clothing.-The call light should be placed within the resident's reach before leaving the room.-He/She did not know if the resident required a standard or adaptive soft touch call light. The resident could use regular but should probably have a soft touch.-He/she was not sure if the resident should have heel protecting boots on while in bed and would get this information by asking the charge nurse.-A resident should wear heel protecting boots while in bed.-Pressure injury interventions were listed in the resident's care plan.-The nursing staff were responsible for implementing interventions and documenting the interventions completed.-He/she had received training on call light placement and interventions regarding assistive devices during an in-service one week ago. Topics included call light placement, making sure call lights were within reach and to use preventative devices as ordered.During an interview on 1/16/26 at 11:11 A.M., Licensed Practical Nurse (LPN) C said:-The resident was bed bound and required total assistance.-He/she would know if the resident required assistance because the resident usually yelled out and by doing rounds and at meals.-The call light should be placed on the resident's bed linens and within reach at all times.-He/she was not sure which type of call light the resident should have. He/she would check the MDS and care plan for that information.-He/she believed that since the resident was bed bound they would require heel protector boots being worn. He/she would find out this information by asking hospice, asking the wound nurse, checking MDS, progress notes or the care plan.--The CNA's could find out this information by checking interventions in Point of Care (POC-enables care staff to document activities of daily living at or near the point of care) or by asking the nurse. -He/she received training through in-services that were held one week ago which included the topics of call light placement and the application of assistive devices. He/she also training on the first Thursday of each month and as needed. During an interview on 1/16/26 at 12:05 P.M., the Chief (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse Officer (CNO) said:-He/she would expect the call light to be within reach of the resident at all times.-All direct care staff was responsible for making sure that call lights were within reach at all times.-Staff should place call lights within reach before leaving the room.-If staff saw that a call light was out of reach, they should make sure it was within reach and secured to the resident's linens or wrapped around the bedrail.-He/she would expect the nursing staff to follow the resident's care plan and implement all interventions.-He/she would expect that physician's orders to be followed at all times.-He/she would expect that a resident with an order for Prevalon boots have them on at all times while in bed as ordered.-Staff could find information about the resident's interventions by checking the care plan, during wound rounds, and looking at the resident's orders.-He/she would expect staff document the interventions and there should be an order in the chart to monitor for placement, a care plan note, and it should be listed in the tasks section in POC.-He/she would expect a resident who was totally dependent on staff for cares and transfers always have their call light within reach. -All direct care staff was responsible to make sure call lights were within reach.-Staff received training on call light accessibility and pressure injury prevention (heel protectors) every month, during orientation and as needed. -There was also a town hall training session on 1/8/26.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure there were physician orders for the use of a Continuous Positive Airway Pressure (CPAP) machine (a device that treats sleep disorders by delivering a steady stream of air through a pressurized mask) for one sampled resident (Resident #18) out of 23 sampled residents. The census was 105 residents. Review of the facility policy titled Physician Orders revised dated May 2023 showed:-Orders may be called, handwritten, fax, or electronically generated by physician. -The physician's orders must be documented completely with sufficient content to clearly convey the provider's intent. Indication for PRN (as needed) orders should be included in the order.-After the authorized provider had completed the orders, the Registered Nurse (RN) or Licensed Practical Nurse (LPN) was responsible to promptly and accurately transcribe all written orders. The RN or LPN must include his/her signature, the date and time of the transcription and credentials.-Orders that were unclear must be clarified prior to implementation.1. Review of Resident #18's face sheet dated 12/29/25 showed he/she admitted to the facility with the following diagnoses:-Acute respiratory failure (a sudden, life-threatening condition where the lungs cannot adequately supply oxygen to the blood (hypoxemia) or remove carbon dioxide (hypercapnia).-Shortness of breath.-Obstructive sleep apnea (a chronic disorder characterized by repeated, temporary pauses in breathing (apneas) or shallow breaths (hypopneas) during sleep caused by the upper airway collapsing or becoming blocked, despite ongoing breathing efforts).-Heart failure.-Need for assistance with personal care.-Hypoxemia.Review of the resident's Annual Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility for care planning) dated 1/14/26 showed: -He/She was cognitively intact.-He/She was dependent on staff for self-care.-He/She was independent for functional cognition.-He/She was dependent on a motorized wheelchair.- CPAP was not marked yes.-Respiratory failure was not marked yes. Review of the resident's current physician orders dated January 2026 showed no orders for the resident being on a CPAP prior to 1/15/26. Review of the resident's Care Plan dated January 2026 showed no mention of or interventions that indicated the use of a CPAP prior to 1/15/26. Review of the resident's Oxygen Saturation daily documentation records showed the staff documented the resident used a CPAP starting on 1/2/26.Observation on 1/12/26 at 10:09 A.M. showed the CPAP was on the nightstand next to the resident's bed. Observation on 1/13/26 at 10:48 A.M. showed the CPAP was on the nightstand next to the resident's bed. Observation on 1/15/26 at 1:00 P.M. showed the CPAP was on the nightstand next to the resident's bed. During an interview on 1/15/26 at 2:35 P.M. Certified Nursing Assistant (CNA) A said: -The resident wore a CPAP every night.-Staff assisted putting the CPAP on him/her at night. -He/She believed the nurses were responsible for cleaning it.-He/She thought there should be orders for the CPAP.Observation on 1/16/26 at 8:45 A.M. showed the CPAP was on the nightstand next to the resident's bed and the mask was lying on the bed. During an interview on 1/16/26 at 9:15 A.M. CNA B said:-He/She had not worked with the resident since he/she came back from the hospital.-He/She did not remember the resident having a CPAP before going to the hospital.-He/She did not know who was responsible for cleaning the CPAP. During an interview on 1/16/26 at 9:30 A.M. LPN A said:-He/She could not remember if the resident had a CPAP machine.-He/She believed the night nursing staff would know more about the CPAP machine. -If a resident did need a CPAP machine the nurses would be responsible for cleaning it.-CAN's would not clean the machine.-The resident should have had an order for the CPAP.-The first time the resident had a CPAP machine, there should have been an order for it.-He/She could not remember when the resident came back from the hospital.-The CPAP should have been documented in the Care Plan and the MDS. During an interview on 1/16/26 at 10:00 A.M., the MDS/Care Plan Coordinator said:-The resident did not have the CPAP when he/she moved into the facility.-He/She thought maybe the family had brought the CPAP in.-The first time he/she heard about the resident having a CPAP was on 1/15/26.-The CPAP should have been documented in the Care Plan and the MDS.During an interview (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 1/16/26 at 10:46 A.M., the resident said:-He/She had the CPAP machine since 2016.-He/She had to wear it every night.-He/She needed staff to put it on him/her every night.-He/She was able to take it off by himself/herself. During an interview on 1/16/26 at 11:37 A.M., the Assistant Chief Nursing Officer (ACNO) said: -He/She just found out on 1/15/26 that resident had a CPAP machine. -When the resident admitted and readmitted to the facility he/she did not have the machine. -He/She didn't think the resident had it for very long.-There should have been an order since he/she had it in his/her room.-He/She would need assistance to put the CPAP on, and the nursing staff would have helped.-Nurses were responsible for cleaning it and it should have been cleaned daily.-The CPAP should have been documented in the Care Plan and the MDSDuring an interview on 1/16/26 at 12:04 P.M., the Chief Nursing Officer (CNO) said:-There should be orders when a resident wore a CPAP.-Nursing staff was responsible for making sure the orders were in.-The resident wore a CPAP.-He/She did not know when the CPAP came into the building.-He/She was waiting to hear from the resident's spouse to see when the machine came into the building. -He/She just learned about the CPAP on 1/15/26. -The resident did not necessarily need help putting it on since he/she was able to take it off by him/herself. -The Charge Nurse would record the Oxygen saturation data for the resident while wearing the CPAP.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Carondelet LLC	621 Carondelet Drive Kansas City, MO 64114

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview and record review, the facility failed to ensure dialysis (a medical treatment that filters waste products and excess fluid from the blood when the kidneys fail, acting as an artificial kidney to keep the body in balance) orders for monitoring the dialysis site were complete to show the thrill (the buzzing vibration felt on the skin over a vascular access (like an AV fistula) from rapid blood flow), and bruit (the whooshing sound heard with a stethoscope, both indicating the access was working properly) would be checked daily; failed to monitor the resident's dialysis site according to the facility protocol; failed to document that the monitoring was completed; and failed to develop a care plan that included how the facility would monitor the resident's dialysis site for one sampled resident who received dialysis (Resident #57) out of 21 sampled residents. The facility census was 105 residents. Review of the facility's Dialysis policy and procedure dated April 2023 showed:-Any line dressings will be done at dialysis unless specifically ordered to be done at the facility. The dressing may be reinforced.-The dialysis site Central Venous Catheter (CVC access for dialysis is a temporary or bridging method for hemodialysis using a soft tube inserted into a large vein (neck, chest, groin) to quickly access the bloodstream, featuring two ports for blood removal and return, ideal for urgent situations but carrying higher infection/clotting risks than permanent access) will be checked daily for signs and symptoms of infection or bleeding.-The dialysis site fistula (a surgically created connection between a patient's artery and vein, typically in the arm, to provide durable, long-term access for hemodialysis, allowing for efficient blood flow for cleaning by the dialysis machine),) will be monitored daily for thrill and bruit.-For residents with fistulas, documentation in the medical record will reflect arm precautions if applicable. Arm precaution includes no blood pressure on the fistula arm, no intravenous lines, and no application of pressure on the arm with the fistula.-Communication with the dialysis center will be done by nursing, dietary and/or social services.-The resident's care plan will reflect their dialysis needs.1. Review of Resident #57's Face Sheet showed the resident was admitted with diagnoses including end stage renal disease (the blood, affecting body chemical balance, blood pressure, and red blood cell production), dependence on dialysis, diabetes, high blood pressure and high cholesterol.Review of the resident's Care Plan dated 12/8/25, showed the resident received dialysis in-house on Monday, Wednesday and Friday. Interventions showed:-Check and change the dressing at the access site per physician's orders and document.-Encourage the resident to go for the scheduled dialysis appointments. -Monitor the Dialysis site for bleeding when returning from dialysis.-Monitor labs and report to the doctor as needed.-Monitor vital signs (blood pressure, temperature, respirations and oxygen) as ordered, and notify the doctor of significant abnormalities.-Monitor/document/report as needed any signs or symptoms of infection to the access site: redness, swelling, warmth or drainage.-NOTE: The care plan did not show where the resident's dialysis access site was or the type of access site the resident had. It did not show how the facility was to monitor the access site.Review of the resident's Annual Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 12/12/25, showed the resident:-Was alert and oriented with minimal cognitive decline.-Needed only supervision with bathing, dressing, toileting, grooming, mobility.-Had lower extremity limitations and used a wheelchair for mobility.-Received dialysis services.Review of the resident's Physician's Order Sheet (POS) dated January 2026, showed physician's orders for:-In house dialysis on Monday, Wednesday and Friday at 3:30 P.M. (ordered 1/13/25).-Remove dressing from the dialysis access site the next day after dialysis treatment (3/1/25).-CVC Location Right chest (1/9/25).-The physician's orders did not show how the facility was to monitor the dialysis CVC, there were no physician's orders to show the resident had a permanent dialysis site such as a fistula, where it was located or how to care for/monitor that site.Observation and interview on 1/13/26 at 10:29 A.M., showed the resident was in his/her room in his/her wheelchair dressed for the weather without odors. He/She had a right below knee amputation with a prosthetic. The resident's left (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	forearm showed the resident had red bruising and several puncture wounds at the dialysis site (fistula site). The resident also had tubing coming from his/her right chest (CVC site) that was covered with a white cotton 4x4 pad. The resident said:-He/She was a dialysis patient and had both a fistula and a CVC.-He/she was not supposed to receive dialysis through the CVC, but yesterday at dialysis they had a hard time getting his/her fistula to work so since he/she still had the CVC they used that to give his/her dialysis treatment. -Normally they used the fistula to give his/her dialysis treatment, and the puncture wounds and bruising was from dialysis staff trying to access the fistula.-He/She still had the CVC but they were eventually going to remove it. Until then, he/she was not supposed to get the CVC wet and the facility staff was not supposed to do anything with it.-The nurses would check to see if there was any bruising or bleeding from the CVC and that was it.-The nursing staff usually removed the bandage from his/her fistula then checked it to make sure it wasn't red or bruised after he/she returned from dialysis.-Sometimes Licensed Practical Nurse (LPN) E would feel his/her fistula, but they did not check it every day and not all of the nurses checked it.-He/She had not seen any of the nurses use a stethoscope to listen to his/her fistula.During an interview on 1/15/26 at 10:39 A.M., the resident was sitting in his/her wheelchair in his/her room and said:-The nurse did not check his/her dialysis site yesterday, because he/she was not the nurse who normally worked on his/her unit, but today LPN E was working, and he/she normally checked his/her fistula. -LPN E had not come in to check his/her dialysis site yet.During an interview on 1/15/26 at 3:08 P.M., LPN E said: -He/She only worked on one of the resident's dialysis days, Monday.-He/She visually checked the resident's CVC site to ensure the CVC was not wet and showed no signs of trauma, bruising or draining. -He/She did the same with the resident's fistula, he/she checked to see that there are no signs of infection.-The resident's fistula had been doing well but yesterday they poked him/her so much in dialysis, that he/she had some significant bruising at his/her fistula site.-He/She documented monitoring of both the fistula and CVC sites on the Medication Administration Record (MAR).-The nurse who was monitoring the areas were supposed to document a progress note if there were any changes to the site noticed.-When he/she checked the resident's fistula, sometimes he/she would feel it to ensure it was flowing and was not clogged. -He/she did not usually listen to the resident's fistula to ensure it was working properly.-The physician's orders did not show they were to check the thrill and bruit or how they were to monitor the resident, but he/she would find out what they were supposed to do.During an interview on 1/16/26 at 9:36 A.M., Dialysis Patient Care Technician (PCT) said: -Once the resident completed his/her dialysis treatment and went back into the facility, the nursing staff was not to touch the resident's dialysis site. -The nursing staff was allowed to change or remove the bandage at the resident's CVC site if it was wet or soiled.-They were not to do anything else but look at the site and report signs and symptoms of infection.-For the resident's fistula, the nursing staff could remove the bandage after he/she came back from dialysis and then ensure there were no signs or symptoms of infection.-They taught the resident in dialysis how to monitor their thrill and bruit to make sure it was not clogged.-If the facility nursing staff noticed any concerns or problem with the resident's CVC or fistula, they were supposed to notify dialysis immediately so it could be addressed.During an interview on 1/16/26 at 9:42 A.M., Dialysis Registered Nurse (RN) said:-CVC dressings were to be changed by the facility nurse only if they got wet or dirty.-Facility nursing staff should monitor the CVC site daily to see if the CVC site got wet or dirty.-If the resident took a shower the nurses were to cover the resident's CVC site. -If the CVC site got wet or dirty, the facility nursing staff was to clean the area immediately and notify dialysis because the area could get infected and sepsis (a life-threatening medical emergency caused by the body's extreme, dysregulated immune response to an infection, resulting in tissue damage, organ failure, and potential death) could occur, otherwise, the facility staff was not to touch the CVC site.-With the fistula, the facility nurse should remove the tape/dressing on the access site 24 hours after dialysis treatment.-The facility nurse staff should look at the fistula site daily to ensure there were no signs and symptoms of infection. -If the resident had an issue with the fistula access site on (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	days the dialysis staff were in the building, the nursing staff should bring the resident to dialysis so they could assess and treat the concern.-If the resident had an issue when the dialysis staff were not in the building, the facility staff were to notify dialysis immediately by telephone or text application.-He/She did not know what the facility protocol was for checking the resident's thrill and bruit daily while in the facility, but they checked the thrill and bruit at dialysis on the days the resident was there.-They communicated to the facility on the days the resident had dialysis regarding the resident's treatments and if there were any concerns or issues noted.During an interview on 1/16/26 at 10:25 A.M., LPN E said:-The protocol for monitoring the resident's dialysis access sites was to visually monitor both the CVA site and the fistula by looking to see if there are any signs or symptoms of infection.-The dialysis center would check the thrill and bruit.-They were to document that they looked at the sites on the resident's MAR.During an interview on 1/16/26 at 12:04 P.M., the Chief Nursing Officer said:-Nursing staff were supposed to monitor for signs/symptoms, bleeding on every shift.-He/She would expect to the nurse to check for bruit / thrill if they had one.-Nursing staff should notify dialysis and clinical (nursing staff) of any issues.-Nursing staff should be doing more than looking at a dialysis site, it should be assessed properly for the type of access site they had.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure follow-up dental appointments were made, which resulted in delay in dental treatment for one sampled resident (Resident #77) who was at risk for dental pain and infection out of 21 sampled residents. The facility Census of 105 residents. Review of the facility's Physician Order Policy dated May 2023 showed:-To clarify requirement and assure that all physicians orders were valid and safe for resident care. -Licensed nursing staff were responsible to promptly and accurately transcribe all written order. Review of the facility's Dental Services policy revised on April 2023 showed:-The admitting nurse performs a dental assessment on each resident upon admission. -If dental care is needed the nurse informs the resident and responsible party. -If the resident would like to use the facility dentist, that dentist will be notified.If the feels that there is a dent emergency, then the attending physician is notified for possible transfer to the emergency room. -Documentation by the dentist is recorded in the resident chart.-Nursing will document dental issue in the nursing note. 1. Review of Resident #77's admission Record showed the resident admitted to the facility on [DATE] with diagnoses of Anemia (a common blood condition characterized by a shortage of healthy red blood cells or a low level of hemoglobin) and cirrhosis of the liver (a serious, progressive liver disease where healthy liver tissue is replaced by scar tissue (fibrosis) due to long-term injury, impairing its ability to filter blood, process nutrients, and perform other vital functions, often leading to liver failure if untreated). Review of the resident's Physician Order Sheet (POS) dated 7/30/25 showed: -Dental referral due to poor dentition (a state of inadequate or unhealthy teeth) and cracked teeth.-Dental Consult as needed order dated 2/17/24.Review of the resident's handwritten doctor progress notes dated 8/7/25 showed:-Diagnosis of poor dentition.-Had a dental visit and the resident was referred for a dental consult for surgery with sedative for Edentulation (the loss of all or most natural teeth). -Pending denture appointment after removal of teeth.Review of the resident's Quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 8/29/25 showed he/she:-Was cognitively intact.-He/she was able to understand others and make his/her needs known.-Had nothing documented under dental for broken or missing teeth.Review of the resident's Oral/dental Health Care Plan dated 9/10/25 showed: -The resident had oral/dental health problems related to poor dentition/cracked teeth.--Coordinate arrangements for dental care, transportation as needed/as ordered.--Provide mouth care as per Activity of daily living (ADL) and personal hygiene.--Monitor/document/report as needed any signs/symptom of oral/dental problems needing attention: pain (gums, toothache, palate), abscess, debris in mouth, lips cracked or bleeding, teeth missing, loose, broken, eroded, decayed, tongue (black, coated, inflamed, white, smooth), ulcers in mouth, or lesions.Review of the resident's medial record dated 10/1/25 to 1/11/26 showed: -The resident did not have any additional documentation related to follow-up dental appointment made or reason for a delay in dental treatment. -Had no documentation or nursing assessment related to ongoing dental pain and discomfort. Review of the resident's Nurse Practitioner (NP) encounter note dated 1/12/2026 showed:-Visit Type was an Acute/Follow-Up.-Had a diagnosis of dental abscess, and poor dentition.-New treatment order for dental abscess for the resident to start on Clindamycin (an antibiotic used to treat serious bacterial infections) 300 milligrams (mg) three times a day for five days. --There was no documentation of what type of infection or where.-Schedule the resident for poor dentition follow-up with a local hospital oral surgeon. Review of the resident's order notes dated 1/12/26 at 9:45 P.M., by the NP showed: -The resident was experiencing discomfort. patient said, that his/her mouth was hurting, and he/she couldn't really chew because each time he/she chewed it was cutting up his/her cheeks. -An order was given for follow-up with a dentist and order for magic mouthwash (made of Benadryl, Maalox, lidocaine) for pain.During an interview on 1/12/26 at 10:55 A.M., the resident said:-He/she had complaints of mouth pain, include gums, tongue and jaw, -He/she (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had difficulty eating due to the mouth pain. -Would like to have dental care and maybe a mouth guard due to his/her sharp jagged teeth. -Received regular schedule pain medication, but no special mouth wash treatment or pain medication for mouth pain. Review of the resident's physician's order note dated 1/12/26 at 12:14 P.M., showed an order for magic mouthwash given every day for five days. During an interview on 1/14/26 at 8:50 A.M., the resident said:-He/she continued to complain of mouth pain.-He/she was not aware of new orders for pain medication or mouthwash treatments.-The teeth he/she had left were very sharp, it felt like his/her gums and tongue were getting cut.-Difficulty in drinking also due to mouth pain. During an interview on 1/14/26 at 9:00 A.M., Licensed Practical Nurse (LPN) F said: -He/she had not assessed the resident for any mouth pain. -He/she was aware the resident had missing and jagged teeth.-The resident had no current treatment for mouth pain.-The resident was on antibiotic for a wound infection in the groin area. -The resident had to get approval from his/her cancer doctor before his/her broken teeth could be removed. -The dentist was at the facility yesterday; it was possible the resident was seen by the dentist then. -The resident did not have an order for mouth rinse or special medication for sore mouth, -He/she was not aware of the resident's current complaints of mouth pain, and his/her gums and tongue hurting. Review of the resident's POS on 1/14/26 at 9:27 A.M., with the [NAME] President of Clinical Operations showed he/she did not find the resident's physician order for mouth/teeth treatment such as a magic mouthwash for dental pain transcribed to the resident's POS. During an interview on 1/14/26 at 10:20 A.M., the Social Services Designee (SSD) said: -He/she found a note that the resident was seen at the dental clinic in October 2025.--The facility did not have documentation from the dental visit and any recommendation needed -The dental provider was going to send a copy to the facility. -The facility did not have the December 2025 documentation for the visit. -He/she did not find SSD follow-up notes or follow-up appointments note in the resident's progress notes. -He/she would expect the Prior SSD to have obtained a copy of the dental visits in October and document any additional referrals or treatments ordered. -Nursing would be responsible for obtaining the physician order and transcribe to the order on the POS. Observation and interview on 1/14/26 at 10:25 A.M., of the resident's mouth showed:-He/she was assessed by facility Regional Nurse and observed to have very few teeth left, which were jagged, broken and sharp. No open mouth sores noted at that time. -The resident had complaints of pain on the right side of the mouth and jaw. -The resident said it did hurt to chew, but he/she needed to eat. Review of the resident's Health Status Note dated 1/14/26 at 2:45 P.M., showed: -The resident continued on antibiotic, Clindamycin HCl Oral Capsule 300 mg give 300 mg by mouth three times a day for infection. -The resident had no complaints or adverse reactions noted on this shift.-NOTE: there was no documentation that the resident had received magic mouth wash for mouth pain. Review of the resident's POS transcribed on 1/14/26 showed:-The resident had order for Magic Mouthwash (made of Benadryl, Maalox, lidocaine 1:1:1 part) give 5 milliliters (ml) every six hours as needed for mouth pain for five days. May substitute for peroxide sore mouth cleanser until Magic Mouthwash arrives. -Clindamycin HCl Oral Capsule 300 mg give 300 mg by mouth three times a day for mouth/tooth abscess infection prevention.During an interview on 1/16/26 at 9:11 A.M., Certified Nursing Assistant (CNA) D said: -The resident had complained of oral pain, and he/she had informed the charge nurse. -The resident's oral pain started after his/her last dental appointment. -He/she was not aware was a special oral care treatment for the resident. During an interview on 1/16/26 at 9:31 A.M., LPN B said the dental care/pain process was to call the provider, assess, refer to dental clinic to be seen, and antibiotic as needed.During an interview on 1/16/26 12:04 P.M. the Chief Nursing Officer (CNO) said: -When a resident reported dental pain, he/she would expect the nursing staff to assess the resident's mouth and contact the resident's physician or further orders. Make a referral to the dental clinic for elevation and treatment as needed.-He/she would expect the nursing staff complete a pain assessment as needed. -The nurse would be responsible to address complaints of pain including dental pain to contact the resident's physician for any orders and follow-up needed. -Nursing staff would be responsible for documenting (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	any referrals needed in the progress note. -Nursing staff would be responsible for contacting the dental clinic after the visit for any recommendations and dental treatment plan. -Social Services would be responsible to schedule dental appointments, transportation and any schedule for additional follow-up appointments. -He/she would expect the resident to have documentation of any additional dental appointment sand recommendations for treatment in the resident's progress note by Social Services and by nursing staff. -The resident should not have had to wait 4-5 months to receive follow-up dental treatments for ongoing dental issues.